

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555918	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/07/2024
NAME OF PROVIDER OR SUPPLIER  Fowler Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8448 East Adams Avenue Fowler, CA 93625	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>27137</p> <p>Based on observation, interview and record review, the facility failed to provide adequate supervision for one of two sampled residents (Resident 1) who was a high risk for elopement when Resident 1 eloped from the facility on 5/15/24 at 7:40 PM and was found by the Sheriff's Department on 5/16/24 at 4 AM in the orchard a mile away from the facility.</p> <p>This failure resulted in Resident 1 leaving the facility without supervision for over eight hours which had the potential to cause injuries.</p> <p>Findings:</p> <p>During an observation on 7/7/24 at 2:35 PM Resident 1 was sitting in the lobby smiling and waving hello to visitors. Resident 1 had an approximately 1-millimeter dot size scabbed on the forehead and on the forearm.</p> <p>During a review of Resident 1's Admission Record (AR-contains important information about a patient such as their personal details, the reason for admission and medical history), dated 6/10/24, the AR indicated Resident 1 was admitted to the facility with diagnoses that included traumatic brain injury (TBI, serious injury to the brain that affects problems with how a person thinks, understands, moves, communicates, and acts), and dementia (impaired ability to remember, think, or make decisions).</p> <p>During a review of Resident 1's Care Plan (CP), dated 2/23/24, the CP indicated Resident 1 is an elopement risk/wanderer related to impaired safety awareness, Resident wanders aimlessly. The resident's safety will be maintained. The resident will not leave facility unattended. The CP dated 3/5/24 indicated Resident 1 has impaired cognitive function or impaired thought processes related to head injury (TBI).</p> <p>During a review of Resident 1's Progress Notes (PN), dated 5/15/24, at 11:10 PM, the PN indicated Resident 1 .had not been seen in facility. All staff was searching the entire facility, rooms, restrooms, outside perimeter, parking lot, and nearby streets. Resident was unable to be located . [local police department] were notified.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility document titled Event 5-Day Follow Up (FU), dated 5/20/24, the FU indicated, On 5/15/24, at 7:40 PM PST [Pacific Standard Time] staff notified charge nurse that resident had not been seen in facility. Facility staff started searching entire facility, rooms, restrooms, outside perimeter, parking lot and nearby streets. Resident was unable to be located. [Local law enforcement and many others] went on search for missing resident. Resident was found by [local law enforcement] unit at 4 AM PST on 5/16/24. Resident was found hiding in fields about 1 mile from facility. Around the time resident is estimated to leave the facility [a] family of another resident was leaving the facility. Resident may have slipped out with the group.</p> <p>During an observation of the facility on 6/7/24, at 1:59 PM, an approximately 7-foot-tall metal fence was noted in front of the facility. The entry from the parking area was locked gate with signs indicating FOR OUR RESIDENT'S SAFETY ALWAYS CLOSE AND LOCK THIS GATE and PLEASE SHUT GATE visible from the entry (parking lot) side. A doorbell was present, and once rung, a staff person came and opened gate with a metal key inserted into the gate's doorknob.</p> <p>During a concurrent observation and interview on 6/7/24, at 2:11 PM, with the Infection Preventionist (IP), the entire perimeter of the facility was observed. The 7-foot-tall metal fence was noted surrounding the entire facility. The IP stated there were a total of four gates to the facility, but the staff and visitors enter and leave the facility through the main gate, which was always kept locked with a key. The other three gates were noted to be tightly closed with a padlock and/or chain. There were no visible means for a resident to climb over, or through, the fence. The same signs were noted at the exit (facility side) side of main gate indicating, FOR OUR RESIDENT'S SAFETY ALWAYS CLOSE AND LOCK THIS GATE and PLEASE SHUT GATE. The IP verified the findings and stated, There's no way [Resident 1] could have gotten over this fence.</p> <p>During an interview with the Director of Nursing (DON), on 6/7/24, at 2:40 PM, the DON stated, We are a locked facility. The fence surrounds the entire building, and the only way in or out is through the locked gate. The DON stated Resident 1 was ambulatory. The DON stated before the incident Resident 1 wanted to go to his daughter's house approximately 25 miles from the facility. The DON stated Resident 1 was observed standing near the entry gate watching visitors and staff in and out the facility. The DON stated only the facility staff had a key to the gate. The DON stated we searched for Resident 1 and looked for chairs, barrels against the fence, any methods for him to climb over the fence, and we did not find anything. The DON stated we determined Resident 1 was not in the facility and notified the Sheriff's department. The DON stated Resident 1 was found by Sheriff's department hiding in an orchard a mile from the facility. The DON stated Resident 1 had minor scratches and have healed in a week. The DON stated Resident 1 had cognitive issues and was not able to tell us how he got out. The DON stated we had some visitors leave the facility on 5/15/24 at about 7:40 PM he must have exited the facility when the visitors left. The DON stated facility staff had to be there to unlock the gate for the visitors to exit the facility. The DON stated more likely Resident 1 exited the facility with the visitors without facility staff noticing.</p> <p>(continued on next page)</p>		

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